Senate Commerce, Labor and Agriculture Committee 1

Amendment No. 1 to SB2239

Stanley
Signature of Sponsor

AMEND Senate Bill No. 2239 House Bill No. 2289*

by deleting the language "or the national committee for quality assurance (NCQA." in SECTION 2 and by substituting instead the language "or the national committee for quality assurance (NCQA)."

AND FURTHER AMEND by deleting SECTION 3 in its entirety and by substituting the following language:

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 2, Part 1, is amended by adding the following language as a new section.

§ 56-2-125.

(a) As used in this section unless the context requires otherwise:

(1) “Commissioner” means the commissioner of commerce and insurance;

(2) “Department” means the department of commerce and insurance;

(3) “Group health plan” means an employee welfare benefit plan, as defined in Employee Retirement Income Security Act of 1974 ("ERISA") § 3(1), codified in 29 U.S.C. § 1002(1), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of such a plan. For purposes of this section, “group health plan” shall not mean any plan which is offered through a health insurance issuer;

(4) “Health insurance coverage” means health insurance coverage as defined in § 56-7-2902(13) as well as medicare supplemental heath insurance; and

(5) “Health insurance issuer” means an entity subject to insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. In addition, a “health insurance issuer” also means a pharmacy benefits manager, a third party administrator, and an entity described in § 56-2-121.

(b)

(1) The commissioner shall establish and maintain an all payer claims database to enable the commissioner of finance and administration to carry out the following duties:

(A) Improving the accessibility and affordability of patient health care and health care coverage;

(B) Identifying health and health care needs and informing health and health care policy;

(C) Determining the capacity and distribution of existing health care resources;

(D) Evaluating the effectiveness of intervention programs on improving patient outcomes;

(E) Reviewing costs among various treatment settings, providers, and approaches; and

(F) Providing publicly available information on health care providers’ quality of care.

(2) Nothing in this section shall preclude a health insurance issuer from providing publicly available information on health care providers' quality of care.

(c) There is hereby established a Tennessee Health Information Committee. The commissioner of finance and administration shall give all consideration to policies and recommendations formed by the committee, including those formed by the

committee on any issues in response to a request of the commissioner of finance and administration in his discretion. Any recommendations developed by the committee shall, to the largest extent possible, be consistent with national standards currently under development for multi-payer databases, health care information measures, reporting standards, and measurement methodologies such as those currently under development by national multi-collaborative stakeholders.

(1)

(A)

(i) The public release of any report utilizing data derived from the all payer claims database on quality, effectiveness, or cost of care of health care providers or provider shall require a two-thirds affirmative vote of the committee members present.

(ii) Health insurance issuers that contribute data to the all-payer claims database and providers who are subjects of reports on quality, effectiveness, or cost of care, that utilize data derived from the all payer claims database shall be given such reports sixty (60) days prior to the public release of such reports for the review and submission of comments prior to such public release.

(B) Any other committee action, including but not limited to, adopting policies concerning administration, utilization, disclosure or submission of data from or to the all-payer database shall require a simple majority affirmative vote of the committee members present.

(2) The committee shall develop for the commissioner of finance and administration:

(A) A description of the data sets, based on national standards, if and when available, that will be included in the all payer claims database; and

(B) A method for submission of data.

(3)

(A) The committee shall develop for the commissioner of finance and administration security measures for ensuring compliance with:

(i) The federal requirements of the Health Insurance Portability and Accountability Act of 1996, compiled in 42 U.S.C. § 1320d et seq. ("HIPAA"), and implementing federal regulations; and

(ii) Other state and federal privacy laws.

(B) The committee shall also develop criteria and procedures to ensure that HIPAA-compliant data sets are accessible and shall advise the commissioner of finance and administration concerning any additional privacy issues.

(4) The committee shall regularly evaluate the integrity and accuracy of the all payer claims database.

(5) The committee shall develop policies to make the all payer claims database available as a resource for insurers, employers, providers, and purchasers of health care, to continuously review health care utilization, expenditures, and performance in this state. Such uses shall be subject to restrictions required by HIPAA and other applicable privacy laws and policies as well as to reasonable charges recommended by the committee and set by rule.

(6) The committee shall be chaired by the commissioner of finance and administration or designee and attached to the department of finance and administration for administrative purposes. The committee members shall serve without compensation and travel expenses.

(7)

(A) The committee shall include:

(i) The commissioner or designee;

(ii) The commissioner of health or designee;

(iii) The commissioner of mental health and developmental disabilities or designee;

(iv) The commissioner of finance and administration or designee;

(v) The director of the state division of health planning or equivalent;

(vi) The director of the office of e-health initiatives or equivalent; and

(vii) The deputy commissioner of the bureau of tenncare or designee.

(B) The committee shall include the following members to be appointed by the commissioner finance and administration:

(i) Two (2) physician members. The Tennessee Medical Association is authorized to submit to the commissioner a list of nominees from which the physicians may be selected;

(ii) Two (2) members to represent hospitals. The Tennessee Hospital Association and the Hospital Alliance of Tennessee are authorized to submit to the commissioner a list of nominees from which the representative may be selected;

(iii) One (1) pharmacist member. The Tennessee Pharmacists Association is authorized to submit to the commissioner a list of nominees from which the pharmacists may be selected;

(iv) Two (2) members to represent the health insurance industry;

(v) One (1) member to represent a hospital and medical service corporation;

(vi) One (1) member to represent a coalition of businesses who purchase health services;

(vii) One (1) member to represent a self-insured employer; and

(viii) One (1) member to represent health care consumers.

(8) The committee may appoint one (1) or more subcommittees to provide advice and recommendations related to the operations and use of the all payer claims database, including but not limited to advisory committees on:

(A) Research;

(B) Technology;

(C) Participation by health insurance issuers in the all payer claims database; and

(D) Such other matters as the committee may approve in its discretion.

(9) The members of the Tennessee Health Information Committee appointed by the commissioner of finance and administration as provided in subdivision (7)(B) shall serve one-year terms and shall be eligible for reappointment to subsequent terms; provided, however, that five (5) of the members shall serve an initial term of two (2) years. Vacancies shall be filled for any unexpired terms, and members shall serve until their successors are appointed and have qualified. The initial term of such members shall be deemed to commence on July 1, 2009.

(d)

(1) As required by HIPAA, the all payer claims database shall not publicly disclose any individually identifiable health information as defined in 45 CFR § 160.103. The commissioner shall collaborate with the Tennessee Health Information Committee in developing procedures and safeguards to protect the integrity and confidentiality of any data contained in the database as well as in

developing security measures that would permit health insurers to access price and other information without disclosing confidential information or trade secrets to individuals or entities.

(2)

(A) The all payer claims database, summaries, and source or draft information used to construct or populate the all payer claims database whether in electronic or paper form, and other information submitted under this section:

(i) Shall not be considered a public record and shall not be open for inspection by members of the public under § 10-7-503(a)(1). Further, such information contained in the all payer claims database shall be considered confidential and not subject to subpoena; and

(ii) Shall only be released pursuant to rules adopted by the commissioner after consultation with the Tennessee Health Information Committee. In addition, reports derived from any such information shall only be released pursuant to such rules. Any release of the information shall not result in such information losing its privilege or cause it to be admissible, except in administrative proceedings authorized under the rules adopted by the commissioner.

(B) The commissioner shall, through memoranda of understanding and after consultation with the Tennessee Health Information Committee, allow the use of its data by the department of finance and administration, the department of health, the department of mental health and developmental disabilities, and other departments of state government for the purposes listed in subdivision (b)(1) above.

(e) To ensure that individual patients are not identifiable, the all payer claims database shall contain unique encrypted patient identifiers. Patient names, patient street addresses, and patient social security numbers shall not be included in the database. No information from the all payer claims database shall be made available to the public that reasonably could be expected to reveal the identity of any patient. The database shall contain unique health care provider identifiers that may be used in public reports.

(f)

(1)

(A) No later than January 1, 2010, and every month thereafter, all group health plans and health insurance issuers shall provide electronic health insurance claims and eligibility data for state residents to the commissioner or a designated entity authorized by the commissioner, in accordance with standards and procedures recommended by the Tennessee Health Information Committee pursuant to subsection (c)(2) and adopted by the commissioner by rule.

(B) All group health plans and health insurance issuers shall provide additional information as the Tennessee Health Information Committee recommends and the commissioner subsequently establishes by rule for the purpose of creating and maintaining an all payer claims database.

(C) The Tennessee Health Information Committee and the commissioner shall strive for standards and procedures that reflect national standards and are the least burdensome for data submitters.

(2) The collection, storage, and release of health and health care data and statistical information that is subject to the federal requirements of HIPAA shall be governed by the rules adopted in 45 CFR parts 160 and 164.

(A) All group health plans and health insurance issuers that collect the Health Employer Data and Information Set (HEDIS) shall annually

submit the HEDIS information to the commissioner in a form and in a manner prescribed by the National Committee for Quality Assurance (NCQA).

(B) All health insurance issuers shall accept electronic claims submitted in the format required by the Centers for Medicare and Medicaid Services.

(3) If any group health plan or health insurance issuer fails to submit required data to the commissioner on a timely basis, the commissioner may impose a civil penalty of up to one hundred dollars ($100) for each day of delay.

(g) The commissioner, in the commissioner's discretion, may allow some group health plans and health insurance issuers to submit data on a quarterly basis. The commissioner may also establish by rule exceptions to the reporting requirements of this section for entities based upon an entity's size or amount of claims, or other relevant factors deemed appropriate.

(h)

(1) The commissioner may, subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules and regulations for purposes of implementing this section. The commissioner is authorized to promulgate the initial rules as public necessity rules pursuant to § 4-5-209 prior to January 1, 2010 for the purpose of creating the all payer claims database.

(2) The commissioner of finance and administration may, subject to the Uniform Administrative Procedures Act compiled in title 4, chapter 5, promulgate rules and regulations concerning the operation of the all payer claims database and the distribution and use of information maintained or created thereby. The commissioner of finance and administration is authorized to promulgate the initial rules as public necessity rules pursuant to § 4-5-209 prior to January 1, 2010, for the purpose of creating the all payer claims database.

SECTION 4. This act shall take effect upon becoming law, the public welfare requiring it.